A VNSNY Transitional Care Program with a leading health plan reduced readmissions among high-risk members.

- Exceeded target goal for reducing 30-day readmissions
- Achieved 100% member adherence to follow-up appointments
- Attained high levels of patient satisfaction

The Need
- A large Medicare Advantage plan identified a population of members who had frequently been admitted to the hospital
- Population putting significant strain on health plan costs
- Both payer and provider recognized the need for interventions that could reduce 30-day rehospitalizations

Program Overview
- VNSNY partnered with the health plan to co-create a transitional care program designed to reduce avoidable readmissions by:
  - Improving transitions from inpatient and community settings
  - Improving members’ health through achievement of self-care goals
- Targeted medically and psychosocially complex members at high risk of rehospitalization
- Transitional care begins pre-discharge and continues 30 days post-discharge

Key Program Elements
- Interdisciplinary team
  - Led by VNSNY Registered Nurse
  - Includes social workers and health coaches
- Early and ongoing assessment
  - Bedside assessment in collaboration with hospital staff to reduce length of stay and optimize hand-over
  - Initial on-site stratification using health plan’s model for identifying risk cohorts; then reconciled with cohorts from VNSNY predictive risk algorithm, including social determinants of health
  - Continued assessment at home to guide patient care plan
• Care coordination, in person and telephonic, throughout 30 days post-discharge
  o Care plan and medication reviewed within 48 hours
  o Weekly face-to-face or telephonic encounters (depending on risk score)
• Emphasis on patient activation, education and self-management
• Engagement with member’s PCP, as well as other community-based providers and resources

**Improved Outcomes**

• Reduced hospital admissions¹
  o Exceeded target goal for reducing 30-day readmissions
  o Average readmissions rate for program was 6% to 9%
• Greater physician visit adherence²
  o 100% appointment adherence
  o 94% of members brought PHR to appointment
• Improved member satisfaction³
  o 70% of those who completed program were "very satisfied"
  o 65% were "very likely" to recommend program to a friend/colleague
• High engagement rate¹
  o 84% of members who were offered program accepted, more than double the goal
• Increased Patient Activation Measures⁴
  o 25% of participants had improved PAM scores
  o 42% of participants had improved Morisky scores
• Improved medication reconciliation²
  o 94% completed within 48 hours, exceeding goal by 14%
  o 100% completed within 72 hours

⁴ For all participants with matched data set (completed initial and final assessments).